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VAGINAL HYSTERECTOMY*

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Our purpose in presenting this paper is to bring to your attention a technique for vaginal hysterectomy which, in our opinion, has not received the attention that it justly deserves. One year ago the attitude of our clinics towards the operation of vaginal hysterectomy might be expressed by saying that it was regarded as one having a distinct but extremely limited field. As usually performed, the operative difficulties which this route offers, in comparison with any of the abdominal methods to which most surgeons are more accustomed, limits its use to that class of cases in which the abdominal route would be fraught with exceptional dangers, such as very obese women with extensive involvement of an infected cancerous cervix.

During a review last winter of the convenient literature concerning this subject, our Chief, Dr. William Wertenbaker, was impressed by the great possibilities offered by the method devised, employed, and described by the late Dr. Joseph Price, of Philadelphia. Carrying out these conclusions, we have employed his method, or some modification thereof, during our term of service in ten cases. Considered from the mortality rate, condition of the patient post-operatively as regards shock, loss of blood, and the celerity with which the operation may be performed after the technique is developed, the results have fully met our expectations. We have had no mortality in this group of cases. There were two cases of post-operative hemorrhage, one of which was controlled by a single dose of morphine and ergot, and the second by a hand over hand clamping and ligation of the bleeding area.

Our indications up to the present have been:

1. Lacerated eroded cervixes showing an advanced endocervicitis, with ectropion (pre-cancerous cervix).

2. Enlarged fibrotic bleeding uteri (hyperplastic uteri).
3. Comparatively early carcinoma of the cervix, which did not produce fixation of the uterus.
4. Small fibroids of the body of the uterus, which had produced irregular bleeding.
5. Procidencia.

So far, we have not felt justified in employing this method for large fibroids of the uterus, large cysts of the ovary, nor where there is a co-existing pelvic inflammatory disease.

OPERATION

1. Disinfection of the endocervix, and closure of the external os by a four pronged tenaculum forcep.
2. Circular incision at the cervico vaginal junction.
3. Dissection anteriorly to the vesical junction.
4. Dissection posteriorly down to and into the posterior cul-de-sac of Douglas.
5. Enlargement of the opening digitally.
6. Delivery of the uterus through this posterior opening by hand over hand traction with sharp prostatic retractors.
7. Passage of the middle finger of the left hand past the fundus uteri up to the utero-vesicle reflexion of the peritoneum.
8. Completion anteriorly of the bladder dissection with enlargement of the anterior opening digitally.
9. Clamping of the pedicles on each side by suitably heavy forceps.
10. Removal of the uterus.
11. Return of clamps to pelvis and the application of a moist gauze pack.

In from forty-eight to sixty hours the gauze packing is withdrawn and the clamps removed.

On one occasion we were unable to obtain moist gauze packing, and dry gauze was used. When the packing was removed the omentum had adhered to the packing and was brought

* Read before the Medical Society of Delaware, Lewes, September 27, 1932.

down with it. The patient was taken to the operating room, the omentum replaced, and a moist gauze pack substituted. This packing was withdrawn in forty-eight hours without further incident.

ADVANTAGES AND DISADVANTAGES

The operation offers a distinct advantage as to the manner of approach, which to our minds is superior to other ordinary methods with which we are familiar. The operation is not attempted in the presence of acute inflammatory pelvic conditions, or when there is fixation of the uterus; in those cases requiring a perineal repair it means a protracted stay in the hospital since a satisfactory perineorrhaphy cannot be performed with the clamps in place. The perineum has to be repaired at a later date after the clamps have been removed. The subsequent odorous discharge and sloughing from the pedicle are sometimes bothersome. These, however, are inconveniences which are more than offset by the added safety and final results of this method. Whether clamps will continue to be used or whether resort will be made to individual ligations a wider experience will have to decide. It was suggested by one of our medical colleagues, who was present on one occasion, that we use a lighter clamp for the pedicle and accomplish the uterine separation with the Bové knife. So far we have not tried this but believe the suggestion deserves serious consideration or even a trial. With clamps, after the uterus is removed, the pedicles replaced, and the moist gauze pack is inserted there appears to be much more lifting up of the pedicles, giving a longer vaginal vault rather than a foreshortening. Considered from the mortality rate, vaginal hysterectomy has a lower incidence than supra-vaginal hysterectomy, probably because of better drainage and less tendency to peritoneal contamination and shock. This would be difficult to prove from such a small series as we report, but the number performed by Drs. Price and Kennedy fully substantiate their statements.

An article in the *Journal of Urology* for August, 1932, by Dr. Beach points out the high incidence of surgical accidents to the pelvic ureter, not only in vaginal but also supra-vaginal hysterectomy. We feel that by the method described there is little or no danger of this, since the middle finger acts as a guide when

the bladder is being dissected away before the clamps are placed.

Symptoms from post-operative adhesions, while they are reported from vaginal hysterectomy, are far less frequent than after abdominal hysterectomy. In our series of ten cases we have not had any post-operative symptoms: Dr. Kennedy reports a very low percentage in his series.

Dr. Babcock of Philadelphia, in a recent publication of *Surgery, Gynecology and Obstetrics*, describes a technique for performing vaginal hysterectomy, which, in the hands of a skillful operator such as he is, gives remarkable results, but in our opinion does not hold out to the average operator who does comparatively few of these operations in the course of a year the same possibilities as the method described by Dr. Price.

The operation of vaginal hysterectomy in several instances involved an expenditure of considerable physical effort on the part of the operator, and we can concur with Dr. Babcock when he cryptically remarks, "It is the surgeon and not the patient who suffers from the traumatism."

CASE I

Age: 40 years.

Referred by: Dr. Wm. Wertenbaker.

Diagnosis: Precancerous cervix—fibroids.

Operation: May 27, 1932—Vaginal hysterectomy (Joseph Price Method).

Anesthesia: Gas and ether.

Pathological Report: Measures 10 x 3 x 4. On section tumor mass in fundus measuring 4 cm. in diameter and composed of firm white tissue. Cervix eroded, edges everted.

Micro: Fibroma. Cervix—chronic inflammation, necrosis.

Surgical Convalescence: Uncomplicated.

CASE II

Age: 27 years.

Referred by: Drs. L. W. Anderson and N. W. Voss.

Diagnosis: Precancerous cervix—fibroids.

Operation: June 2, 1932—Vaginal hysterectomy.

Anesthesia: Gas.

Pathological Report: Uterus measures 8 x 3 x 5 cm.

Micro: Endocervicitis.

Surgical Convalescence: Slight hemorrhage on the 12th and 14th or 16th day. End result satisfactory.

CASE III

Age: 50 years.

Referred by: Dr. W. E. Smith.

Diagnosis: Complete procidentia uteri—eroded cervix—fibroids.

Operation: June 8, 1932—Vaginal hysterectomy.

Anesthesia: Gas and ether.

Pathological Report: Uterus measures 10 x 4 x 3 cm., cervix enlarged and eroded. On section no tumor mass found.

Micro: Cervicitis.

Surgical Convalescence: Uncomplicated.

CASE IV

Age: ?

Referred by: Dr. M. I. Samuel.

Diagnosis: Precancerous cervix.

Operation: June 21, 1932—Vaginal hysterectomy.

Anesthesia: Gas and ether.

Pathological Report: Uterus measures 8 x 4 x 1 cm. Cervix enlarged m. m. ulcerated.

Micro: Cervicitis.

Surgical Convalescence: Uncomplicated.

CASE V

Age: 39 years.

Referred by: Dr. S. B. Pawlikowski.

Diagnosis: Active carcinoma of cervix.

Operation: July 7, 1932—Vaginal hysterectomy.

Anesthesia: Gas.

Pathological Report: Uterus measures 6 x 8 x 3 cm.; tubes attached, walls thickened.

Micro: Carcinoma.

Surgical Convalescence: Uncomplicated.

CASE VI

Age: 28 years.

Referred by: Clinic.

Diagnosis: Eroded cervix with ectropion—precancerous.

Operation: July 11, 1932—Vaginal hysterectomy.

Anesthesia: Gas.

Pathological Report: Uterus measures 13 x 6 x 4 cm. on section walls thickened, mucous membrane of fundus hypertrophied and red in color.

Micro: Adeno-carcinoma.

Surgical Convalescence: Uncomplicated.

CASE VII

Age: 31 years.

Referred by: Dr. W. W. Ellis.

Diagnosis: Precancerous cervix.

Operation: July 21, 1932—Vaginal hysterectomy.

Anesthesia: Gas.

Pathological Report: Uterus measures 9 cm. in length, on section, walls thickened—mucous membrane red and hyperthrophied. Cervix irregular in outline.

Micro: Hypertrophic endometritis. Cervicitis—cystic.

Surgical Convalescence: Good.

CASE VIII

Age: 47 years.

Referred by: Dr. B. J. McEntee.

Diagnosis: Complete procidentia—cervical erosion—precancerous cervix.

Operation: June 18, 1931—Vaginal hysterectomy.

Anesthesia: Spinal.

Pathological Report: Cervix shows invasive masses of malignant squamous epithelial cells with mitotic figures and marked secondary infection.

Diagnosis: Squamous carcinoma. Body of the uterus shows endometrial hyperplasia with sclerosis of myometrium. No evidence of malignancy.

Surgical Convalescence: Good.

CASE IX

Age: 39 years.

Referred by: Clinic.

Diagnosis: Precancerous cervix.

Operation: Vaginal hysterectomy.

Anesthesia: Gas.

Pathological Report: Gross: Specimen consists of uterus which is centrally enlarged. Measures 8.5 x 8 x 5.6 cm. The endometrium is irregularly thickened. Another irregular specimen 3.5 x 3 consists of mottled spongy red and firm grey tissue. A third specimen consists of the fimbriated end of a tube, to which is attached a thin walled cyst 2cm. in diameter.

Microscopic: The muscle cells of the uterus are large. The endometrium shows a hyperplasia with many polymorphonuclear leukocytes.

Diagnosis: Pregnant uterus with necrosis and acute inflammatory reaction of the placenta.

Surgical Convalescence: Good.

Note: By Dr. W. W. Case IX.

No mention made of chief pathological lesion: (lacerated) eroded cervix. The uterus certainly was not pregnant at time of operation and the gross appearance did not indicate that it had recently been in this state. A small necrotic mass near the fundus closely resembled corio-epithelioma or andeno-carcinoma.

CASE X

Age: 42 years.

Referred by: Clinic.

Diagnosis: Procidentia uteri—cervical erosion.

Operation: Vaginal hysterectomy.

Anesthesia: Gas.

Pathological Report: Gross: Half of a uterus.

- (1) Cervical portion appears everted.
- (2) small pedunculated mass 1 cm. long in cervical canal.
- (3) Endometrium appears thin and injected.

Microscopic: Endometrium is normal in appearance. The glands of cervix show frequent cystic dilatation and there is a diffuse infiltration of lymphocytes in the submucous layer.

Diagnosis: Chronic endocervicitis; normal endometrium.

Surgical Convalescence: Good.

DISCUSSION

DR. RAYMOND A. LYNCH (Wilmington): From the general surgeon's standpoint, I feel that any operation or technique for any operation which is the simplest, safest and most rapid is the best technique. I have seen Dr. Wertenbaker and Dr. Preston do two or three of these operations. I was also fortunate enough, while associated with Dr. Wayne Babcock, to help him in several of his operations, in which the ligation method was used.

Dr. Preston spoke of an article in the S. G. & O. a short time ago. In the hands of Dr. Babcock I would dare say that it was most skillfully and ideally done. However, in the hands of the general surgeon, and in a great many gynecologists' hands, it is quite a difficult operation. Unfortunately these pictures—not these especially, but any pictures—do not portray the real value of the steps of an operation.

However, you see in this first moving picture especially how few real steps were made, and in

the few cases that I saw him do it really was very impressive. I think in a selected group of cases this type or technique of vaginal hysterectomy is almost ideal.

PRESIDENT HOCKER: Any further discussion?

DR. WILLIAM WERTENBAKER (Wilmington): I want to concur in what he says about the value of this method of performing vaginal hysterectomy. Whether the operator strictly adheres to all of the procedures, or varies them to suit his own purposes, is immaterial; but his work will be simplified by complete understanding of the mechanics of this method.

The dissection is certainly much simpler by this method than any other I have ever used before. The bladder and the uterus are very much less apt to be injured than where we simply pull the uterus down.

In regard to the clamps, I think that is entirely a matter for each individual operator to decide for himself. The clamps are certainly advantageous, but they have some very prominent disadvantages; there is no doubt about that. The chief advantage seems to be the elongated vaginal wall. I recently examined one of these cases that we did about three months ago. She has a long vaginal wall for a normal woman.

One very important thing Dr. Preston brought out is the use of the moist pack instead of the dry. On one occasion we didn't have a moist pack; we had to use a dry pack and the patient protested very vigorously.

Dr. Preston has gone over the indications. They very properly come in at this time. I heartily agree with the old axiom that if you are going to cure cancer, cure it when it begins. Multiple lacerations of the cervix, chronic endocervicitis, etc., which bleed easily when you touch them, certainly are one of the most, if not the most, fertile field in the human body for the development of cancer. If we wait until we can make a positive diagnosis in those cases by looking at them or even by biopsy, we are certainly going to lose a high percentage of people that you would otherwise save.

Of course you will say very truly, "You will operate on some women, do radical operations on them, that would never develop cancer." That may be true, but we unquestionably take out a great many appendices that, if left alone, would recover, but we know perfectly well that as a group the time to operate for appendicitis is

when you make the diagnosis. I think the same analogy applies here. When you have a field in which we know the incidence of cancer is as high as it is in a field of that kind, I think it should be removed.

The operation in regard to cases in which cancer has already developed remains as it always has remained, a matter of judgment on the part of the operator. One operator will feel that it is safe or advisable to operate in a certain case, whereas another one might not think so. We do not expect to cure those cases.

One of our cases was a well developed case of cancer, much further progressed than we had expected to find. When we got into the uterovesical space we found it was very extensive, so much so that I feared a vaginal fistula within 48 hours. We used about four times the average dose of radium on this woman. At the end of 48 hours she was still going about doing her work taking care of nine children. That was four months ago. She is not going to get well. However, I do feel that we have extended her life and her usefulness.

PRESIDENT HOCKER: Any further discussion?

DR. W. E. BIRD (Wilmington): Mr. Chairman, I hope you will bear with me once more. I do not intend to discuss every paper on this program, but it happens to be two in a row.

I am sorry to have to take issue with Dr. Wertenbaker on the cancer of the cervix question. He admits that, in extensive carcinomas hysterectomy, certainly by the vaginal route, would be contra-indicated. I believe he should carry his contra-indication to the point of *any* cancer of the cervix. The feeling seems to be spreading among the profession, certainly among those who are in contact with radium clinics or who are keeping abreast with the statistics from those clinics, that operation for cervical carcinoma is hardly a reasonable procedure.

Why subject a woman to what is, after all, a sizeable surgical procedure, when at the end of five years you have only 18 per cent of cancer cures; whereas with radium, provided you have sufficient radium to treat the patient really right, there are 19½ per cent cancer cures of the early cervix cases—the group he is including—at the end of five years?

I contend that any procedure that offers one and one-half per cent more—even if it were only one and one-half per cent less—cancer cures at

the end of five years, which did not subject the patient to a rather serious surgical risk, is a better procedure.

Dr. Wertenbaker does not agree with that. We have talked this over before. I think it is only fair to state publicly that we do not agree.

PRESIDENT HOCKER: Any further discussion? Dr. Preston, do you have anything to say in conclusion?

DR. PRESTON: No.

A FEW OF THE LESS COMMON COMPLICATIONS IN SURGERY*

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One of my earliest and most vivid recollections connected with the study of surgery is the vision of a little red volume that used to occupy a conspicuous place on the bookshelves of my teacher's library. This little volume bore the graphically reminiscent title "Mistakes and Accidents of Surgery," and often as I sought among its neighbors for light on some problem that was annoying me at the moment, this same book, with a warning grimace, would catch my eye as if to remind me how much more I could tell if I were to set down my own experience, of a few years, between two red cloth binders. But, though I have chosen as my subject complications arising in the practice of surgery, it is not offered as a confessional—perhaps that role will be filled at another date when my time is not so limited. And it is not my purpose to deal with those unhappy sequellae that we associate with certain specific technical procedures, as eg., biliary fistula following cholecystectomy, or persistent vomiting following gastro-enterostomy. And I shall not touch, either, upon those disturbing consequences that are related to certain pathological entities, viz., intestinal obstruction resulting from acute appendicitis, paralytic ileus ensuing upon resection of the colon, etc.

Rather, I should like to direct your attention to some of the less frequent complications met with in the general practice of surgery—conditions that appear independently of the type or location of the pathology present, and irrespectively of the mechanical measures employed in treating that pathologic process.

* Read by title before the Medical Society of Delaware, Lewes, September 28, 1932.

The first that occurred to the writer was that of *acute parotitis*. This clinical phenomenon has appeared frequently enough in our experience, and has presented features of sufficient gravity, to justify its inclusion in a report of this kind. Strangely enough, post-operative parotitis has received little attention from those disposed to write on surgical subjects—eg., upon consulting the Quarterly Cumulative Index from January, 1927, to July, 1931, one discovers that there has not been a single contribution to any of the recognized national surgical journals (Surgery, Gynecology & Obstetrics, Annals of Surgery, American Journal of Surgery, Archives of Surgery, and Surgical Clinics of North America) during this period of three and a half years.

The scope of this paper does not permit of reference to the various theories advanced as to the etiology of post-operative parotitis. However, it is of practical significance to observe that the most recent studies of this complication lead us to the most plausible explanation of its origin, that of oral sepsis. This attitude toward its cause establishes a fundamental premise for its treatment, viz: thorough and diligent hygiene of the mouth. Rigid observance of this practice as a part of the routine preoperative preparation of patients will certainly prove to be the most conservative, as well as a very effective, means of dealing with this complication.

Acute parotitis usually makes its appearance along toward the fourth or fifth post-operative day, although it has been reported as occurring as late as the eighteenth day after operation. Its onset is marked by an elevation of temperature, (in the more severe cases, frequently by rigor), complaint of pain near the angle of the jaw, and within eighteen to thirty-six hours by the appearance of swelling just anterior to the auricle or below the lobe of the ear. This area will be tender even to light palpation. At this stage an ice bag locally, the chewing of gum, and ingestion of large quantities of fluids, constitute the most direct measures toward aborting the infection, and if on the following day, the temperature has not risen further nor the swelling increased, one may reasonably look for self-limitation and gradual resolution of the process. However, if pain persists, swelling is advanced, and the temperature maintained or higher, it is almost a surety that suppuration

has begun, and the sooner surgical relief is given the better—both for the conservation of parotid tissue, and of greater importance—for controlling sepsis.

One's judgment as to time for incision must, of course, be guided by the clinical appearance of the patient, his general systemic resistance, and by the degree of local inflammatory signs, but in general we have adopted the policy of *early* operation—decompression before pressure necrosis has occurred. (It is surprising to observe how quickly the firm, dense capsule of the gland produces gangrene of the cellular structure beneath it.) *Do not wait for fluctuation*. By the time this sign is obtainable the patient is severely toxic, and may even have reached a point beyond salvaging.

Along with the dictum of *early* operation, I should like to emphasize the importance of *adequate* operation. Our experience has convinced us of the necessity of wide exposure of the parotid region and liberal incision of the capsule to relieve tension. Under nitrous oxide-oxygen anaesthesia, a vertical incision is made parallel to the anterior border of the auricle and curving downward and backward to the angle of the jaw. The mesial flap is then dissected backward and retracted strongly. Multiple incision of the capsule is made and the gland itself then opened at several points, frequently using the electric cautery; these wounds are then packed with dichloramin-T gauze. Scarring has not been marked where proper post-operative attention was given to the wound.

To date we have not had a death from post-operative parotitis. We have had eight cases that required surgical decompression, and most of these were of an aggravated type. Experience in these cases had demonstrated to us, very forcibly, that death can occur by way of an overwhelming sepsis consequent to parotid infection, and such fatalities have been reported by others. Certainly, once this condition is recognized as of the fulminant type, and the diagnosis is never obscure, procrastination spells disaster.

The second complication that I should like to refer to, is that of *peripheral embolism*. In this connection, I must confess to a very limited experience, and yet one productive of certain precise conclusions that seem deserving of expression at this time.

The obstruction of large arteries by emboli occurs independently of operative procedures, but the same principles—diagnostic and therapeutic—apply, irrespective of underlying causative factors. These features can be grasped quickly and clearly, perhaps, by attention to the following clinical case, one of the author's, seen on January 17, 1928.

Patient was a male, sixty-six years of age, admitted to the hospital with unmistakable evidence of upper abdominal peritonitis, maximum signs presenting themselves in the upper right quadrant. Auricular fibrillation was present, with a ventricular rate of 124-132; urea nitrogen was reported at thirty mgms. per one hundred cc. of blood; leukocytic count was 20,500. Faint jaundice was apparent.

After few hours delay for introduction of fluids, morphin, and digitalization, the patient was operated upon under local anaesthesia. Free bile was found in subhepatic space and in right paracolic groove, the results of a perforated, gangrenous gall bladder. Cholecystostomy and subhepatic drainage were done, and the wound left open except for figure-of-8 silk-worm gut through and through suture at lower angle.

The patient progressed surprisingly well until about forty hours after operation, when it was reported to the house physician that he was complaining of agonizing pain in his right leg. Morphin sulphate, gr. $\frac{1}{4}$, was ordered, without appreciable effect, and when seen by the author some four hours later, the man was in obvious shock, and complaining of severe pain in the thigh and about the right knee joint.

Examination at this time revealed that entire right lower extremity, from the junction of lower and middle thirds of thigh on down, was marble cold, completely blanched and insensitive (heat, cold and tactile sense). The lower third of the thigh was hyperemic and sensitive to palpation along its inner aspect. No pulsation could be elicited over the dorsalis pedis, popliteal, or lower femoral arteries. A faint impulse was obtainable over the site of the common femoral artery, just below Poupart's ligament. Diagnosis was made of arterial embolism, and embolectomy was advised.

One and one-half hours later, approximately six and one-half hours after onset, arteriotomy and embolectomy were done under local anaesthesia. A vertical incision, about 8 cm. in

length, was made through Scarpa's triangle until the common femoral artery came into view. A faint pulsation was noted close to the inguinal ligament, and a definite point at which it ceased was readily seen. Below this point the vessel was markedly narrowed. The anterior wall of the artery was opened, and immediately a firm organized thrombus attempted to extrude itself. With a pair of small curved forceps, this thrombus was gently elevated until finally a firm, unfragmented clot, measuring 53 cm. in length, was removed. Examination showed a small spur at its upper end where the clot had projected itself into the profunda branch, and distally a definite bifurcation where it had lodged in the popliteal artery.

Upon removing the Murphy clamp proximal to the arteriotomy wound, blood flowed freely; the clamp was reapplied, and the vessel closed with a double row of oiled-linen sutures. Pulsation was seen to be transmitted through the site of the arteriotomy, and the assistant reported that popliteal pulsation had returned. The wound was closed, and the patient returned to bed, the affected limb wrapped in cotton, elevated and kept warm with an electric baker.

Operation was tolerated well, and on the following day the patient was clinically improved, with circulation of lower one-third of thigh better, as shown by color of skin, by its warmth, and by a return of tactile sensation. The leg from knee down to and including the foot was cold, mottled, and insensitive. Muscular use was abolished.

During succeeding seven days, the condition of the extremity remained same, except for the gradual development of a dry gangrene of the leg. No popliteal pulse was demonstrable, but that over lower Scarpa's triangle was positive.

Patient ran an afebrile course until the tenth post-operative day, when he seemed more listless and apathetic. The abdominal wound was suppurating freely, with profuse bile drainage into a glove attached to the cholecystostomy tube. He gradually lost ground, and died on the fifteenth day after first operation, thirteenth day following embolectomy. Death was attributable to sepsis from ruptured gall bladder, advanced cardiovascular disease, and gangrene of leg, the result of arterial embolism.

The only other case that has come under my direct observation was one of a woman, seen one

and one-half years later, referred to Dr. J. G. Spackman, and seen and operated upon jointly with him. At the time of admission, some thirty-six hours after the onset of arterial obstruction, the right lower extremity distal to the knee joint was cold and insensitive. At operation a fragmented embolus was recovered just below bifurcation of common femoral artery. This patient died five days later without recovering the circulation in the leg, but with the circulation of the thigh unimpaired. Amputation at the knee was not done because of the patient's poor general condition. In this case the embolism undoubtedly was the result of longstanding endocarditis. And, although, embolectomy failed to save the patient's life, this second experience contributed an additional element to strengthen my conviction of the worthwhileness of mechanical removal of emboli lodged in the arteries of the extremities.

The findings at operation in both of these cases could not fail to impress one with the possibilities inherent in embolectomy when embolism is recognized early and operation undertaken promptly. To quote Pemberton, of the Mayo Clinic (1928): "In America today, there is no established operative procedure of equal simplicity fraught with so little risk and with such dramatic potentialities that has been so woefully neglected as embolectomy for circulatory disturbance of the extremities." Koster, who has also reported two cases of embolectomy, says: "Perhaps no procedure in the realm of vascular surgery has such brilliant possibilities as the early removal of an embolus lodged in a large artery." Key, of Stockholm, reports that of seventeen operations of embolectomy, personally performed since 1912, eight were successful.

The mortality rate will of necessity be high, and yet more conservative treatment is certain to eventuate with 100% of failures.

Post-operative embolism of arteries of extremities is not a frequent occurrence, but neither its rarity, nor its high percentage of fatal consequences justify our indifference to it once it does develop, and because my own experience convinces me that some cases can be spared by embolectomy, I present it here in this brief way.

And now, I should like to present for your consideration a third complication, this, also, one not dependent upon the type of pathology, its

location, character of anaesthesia used, or the operative technique employed.

I refer to post-operative massive collapse of the lung. Here we deal with a condition that is not surrounded with the discouraging and fateful possibilities that are so inseparable from arterial embolism, for pulmonary atelectasis, though much more frequent than arterial embolism, has, happily enough, a high percentage of recoveries, and in the majority of instances, the treatment is exceedingly simple.

The mere mention of this condition prompts one immediately to launch upon a lengthy review of the experimental and clinical work, that has been done during the past few years, in an effort to better understand the mechanism responsible for post-operative atelectasis. This phase of the question, i. e., the mechanical factors involved in producing massive pulmonary collapse, has provided a fertile field for those of speculative and research inclinations, and the story of their efforts reads like a romance. However, this very interesting and important aspect cannot be dealt with here.

For our purpose let us understand massive atelectasis, occurring as a post-operative development, to mean a sudden diminished aeration of a greater or lesser extent of lung tissue, caused by obstruction of a bronchus by thick tenacious mucous, and giving rise clinically to following symptoms and signs: elevation of temperature, rapid pulse, increased respiratory rate, cyanosis, dyspnoea, increased opacity to Roentgen ray of area involved, deflection of mediastinal contents toward side of pulmonary collapse, elevated diaphragm, and perhaps visible flattening of chest wall on affected side.

Such, briefly, is the clinical picture of massive collapse of the lung. In the combined surgical services of Dr. Spackman and the author, it has been recognized ten times in the past six years. In one of these, the pulmonary atelectasis was the cause of death. In general, however, the mortality rate is very low, reinflation of lung occurring spontaneously, or following very promptly upon institution of postural treatment, or, as is sometimes required, upon aspiration via the bronchoscope.

Massive pulmonary atelectasis is a distinct clinical entity, not to be confused with so-called post-operative pneumonia, pulmonary infarction, ether bronchitis, or similarly described lesions.

Its proper recognition is dependent upon x-ray examination, in which case the findings are unmistakable. However, bed-side observation yields sufficient data in most cases to suggest the diagnosis to one who is familiar with the course of such cases. Sudden elevation of temperature with tachycardia, hyperpnea and dyspnoea, cyanosis, and pain in the chest, together with auscultatory evidence varying from localized absence of breath sounds to transmitted bronchial breathing with exaggerated vesicular breathing from the opposite chest, and visible and tactile demonstration of displaced heart to the side of the abnormal physical signs, constitute the clinical features of this pathological phenomenon, and should be immediate ground for requesting x-ray corroboration.

Immediately upon recognition of this condition, two courses of action offer themselves—postural, and bronchoscopic drainage. The former, first advocated by Sante, is simple and usually entirely effective. It consists in turning the patient so that the sound lung is dependent; and the patient is then encouraged to cough gently or breathe as deeply as possible. Further efforts to stimulate the cough reflex by tapping chest or by rolling the patient from side to side is also helpful.

Bronchoscopic aspiration of mucous must sometimes be resorted to, though in our single case in which it became necessary even this procedure was ineffective, and the patient died some two weeks later, apparently of toxic absorption.

In this condition, just as in parotitis, preventive measures are of particular importance, and in this connection, Scott and Cutler have advocated hyperventilation of lungs immediately at the end of the operation by forcing inspiration of carbon dioxid-oxygen. Other aids have been found in having the patient change position frequently after operation, breathe deeply several times during the first few days, and in avoiding over-sedation, so that the cough reflex is not inhibited.

Post-operative pulmonary atelectasis, in spite of its apparent benignity, is not wholly without danger, as proven by our own fatal case. It is a distressing experience for the patient and may give some anxious hours to the surgeon and the patient's family, if they are ignorant of what has happened.

Our own cases cover those in which ether, nitrous oxid-oxygen, and spinal anaesthesia have been used, and include also one case in which the operation was upon an extremity, with massive collapse occurring five days after amputation of an arm. No case in which local anaesthesia was employed has been recognized by us, though the nature of the lesion leads us to believe that it is a possible occurrence even with this type of anaesthesia.

Undoubtedly many cases have been overlooked in the past, some perhaps terminating in death, which, if properly appreciated at the time, might have been saved by carrying out the indicated procedures—either postural or bronchoscopic drainage.

Certainly this third post-operative complication deserves our thorough understanding of its nature if we are to give our patients the full benefits they have a right to expect at our hands.

WHY POTASSIUM IODIDE SHOULD NOT BE USED IN THE TREATMENT OF TUBERCULOSIS*

CARLETON C. FOOKS, M. D.,
Frankford, Del.

When Nature walls off a tuberculous process in the lungs she does so by the deposition of lime salts about the necrotic area. Tri-calcium phosphate is the material that walls off and seals up the diseased area. When potassium iodide is administered it ionizes into positive K, and negative I. Iodine is a powerful oxidizing agent, and the water present, which also ionizes into positive H and negative OH ions, is caused to liberate negative O ions, which acting upon the insoluble tri-calcium phosphate barrier causes it to break down into the soluble calcium hydrogen phosphate, and the soluble calcium hydroxide, thereby allowing the necrotic and caseous process to spread, and increasing the chances of a break, and of a consequent haemorrhage.

Now conversely, the giving of iodides is indicated in syphilis, because the gumma and tubercle, being essentially the same—that is, consisting of caseous matter, hyaline and fibrous matter, and some lime salts—is disintegrated by the liberated oxygen as explained above. Being "new formations" and hence not so compact,

* Read before the Sussex County Medical Society, Georgetown, December 8, 1932.

they are more readily attacked by the oxygen than surrounding tissues, in the same manner that hydrochloric acid will more readily dissolve pulverized calcium carbonate than a dense lump, because there are more areas for contact.

In the case of a syphilitic gumma it is the proper thing to break it down and liberate the spirochetes, because for syphilis there is a specific-mercury, and after being liberated the mercury can then attack and kill them; whereas, in tuberculosis there is no specific to kill the tubercle bacillus after it is liberated. Furthermore, in tuberculosis, even if there were a specific to kill the bacilli, it would be poor policy to give potassium iodide to break down the tubercles in order to give the specific a chance to kill the liberated bacilli. The reason for this is because, whereas syphilis is rare in the lungs but is usually in the less vascular parts of the body, in tuberculosis the lungs are the most susceptible part of the body, and if the barrier be broken down then the individual is liable to die directly of a haemorrhage, or indirectly from anaemia produced by many small haemorrhages before the specific would have time to kill off the tubercle bacilli. The proposition here is to wall it off.

Bearing in mind that every time the heart beats as much blood goes to two comparatively small lungs as goes out of the aorta to the rest of the whole body, the large volume of blood present, and the large vascular area would indicate a situation in which a great haemorrhage would result *should* a break occur.

In arterio-sclerosis and in syphilitic aortitis, potassium iodide is given to tend to make the vessel walls more resilient. This is because the oxidizing agent tends to remove the calcium deposits, and the hyaline and fibrous matter in the vessel walls, and consequently the vessel then becomes more resilient.

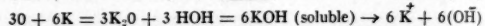
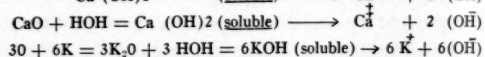
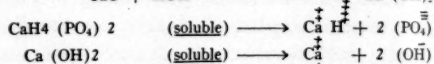
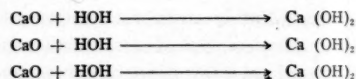
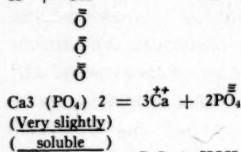
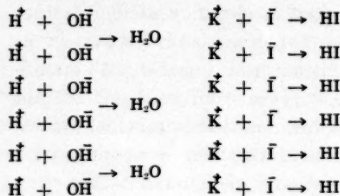
In pleurisy with effusion, if it were non-tuberculous, the suggestion is advanced that potassium iodide, by liberating oxygen, which in turn would tend to disintegrate the new-formed fibrin plugging the interstices of the pleura, might be beneficial in thereby promoting absorption.

The chemical reactions are as follows:

Electromotive Series

Ca Mg Fe H Cu Hg

There is a tendency for the calcium to ionize. Those higher replace those lower in the series.



Tri-calcium phosphate is practically insoluble, and hence ionizes very slightly because of its low solubility product, but as the more readily ionizable and hence more soluble $\text{Ca}(\text{OH})_2$ and $\text{CaH}_4(\text{PO}_4)_2$ are formed and carried away by the blood stream, this process continues until all of the calcium barrier is broken down.

Higher Carbohydrate Diet Method in Diabetes Mellitus: Analysis of One Thousand and Five Cases

During the past seven years P. A. Gray and W. D. Sansum, Santa Barbara, Calif. (*Journal A. M. A.*, May 20, 1933), observed the effects of diets which, so far as their carbohydrate content is concerned, are more liberal than the so-called classic or strict diabetic diets. Their material consists of 1,055 cases of glycosuria admitted to the metabolic division of their hospitals. Of these patients, 1,005 were considered to have true diabetes mellitus, 31 potential diabetes and 7 renal glycosuria. The material is equally divided between the sexes, there being 504 men and 501 women. A higher carbohydrate diet does not mean an unlimited or "free choice" diet such as Stolte has recently advo-

cated. The average type of diet that has been used during the period covered by this study in each type of diabetes has been that the number of grams of carbohydrate has averaged slightly more than twice that of fat used. The tendency during the last few years has been to use from 3 to 4 Gm. of carbohydrate per gram of fat without any change in the calory-to-kilogram ratio. The adults have received 30 or less calories per kilogram except when such complications as extreme malnutrition, tuberculosis or hyperthyroidism have been present. With children, the diet has been more liberal. In the preparation of the diets, all staple foods except cane sugar, honey, and foods sweetened with any of these are employed. Aside from this restriction, the patient may select what particular foods he likes within the limitations imposed by the diet formula. Fruits, vegetables, milk, eggs, meat, bacon, bread, cereals, butter, cream and salad dressings constitute the diet. The authors believe that the seven-year period covered by their study is a sufficient length of time in which to evaluate adequately the usefulness of the higher carbohydrate diets. All patients included in this study received such diets throughout their period of treatment. Seventy were under continuous observation for the entire seven years, 16 for six years, 43 for five years, 57 for four years, 97 for three years, 115 for two years, 177 for one year, and 430 for less than one year. No case was included which did not receive treatment for at least one week. The authors' records are sufficiently complete on seventy of the original patients who received the higher carbohydrate diet in 1925 to justify critical analysis. They present a record of the age, weight, diet and insulin dose of each of these patients when they first became stabilized on the higher carbohydrate diet and the corresponding data when last examined. An improvement in tolerance as measured by a lower insulin dosage, an increased diet, or both, has been frequent among these patients. In forty of these cases (51.7 per cent) there has been a reduction in the insulin dose either on the same diet or on one of greater caloric value. One patient has been able to increase his diet on the same insulin dosage, and another, who did not receive insulin, has been able to increase his diet without insulin. In ten cases (14.3 per cent) the

insulin dosage today is higher than it was at the beginning of the period of treatment, but the diets are also greater. Two patients (2.8 per cent) have had to increase their insulin dosage, either on the same diet which they took in 1925 or on one of lower caloric value. Fourteen cases (20 per cent) require less insulin than they did five years or more ago, but at the same time the daily caloric intake is lower. The reductions in diet and in insulin dosage are not parallel in all cases. Of the ninety-five patients (of the whole series) who died, arteriosclerosis was the chief single cause. The incidence of arteriosclerosis seemed to be more closely related to the age of the patient than to the duration of the diabetes.

Cardiac Asthma (Pyroxysmal Cardiac Dyspnea) and the Syndrome of Left Ventricular Failure

Soma Weiss and George P. Robb, Boston (*Journal A. M. A.*, June 10, 1933), present a study of the dynamics of the peripheral and pulmonary circulations in cardiac asthma, and describe the relation of the circulation to clinical symptoms and signs of left ventricular failure and to the mechanism of asthmatic attacks. Whereas the peripheral circulation between attacks of cardiac asthma is usually normal, the pulmonary circulation exhibits engorgement and evidence of pulmonary hypertension. Simultaneous measurements of the lung volume and its subdivisions, and the pulmonary circulation between attacks reveals a functional pulmonary emphysema caused by disturbance of the pulmonary circulation. With improvement, the pulmonary circulation first becomes normal, followed by disappearance of the functional emphysema. In the precipitation of attacks, the coexistence of subacute failure of the left ventricle and acute precipitating factors is essential. Acute pulmonary hypertension, a secondary intense functional emphysema, and pulmonary edema are the main features of the attacks. The volume of the blood flow through the lungs is normal or decreased, the velocity usually decreased. The pulmonary rather than the peripheral circulation is related to orthopnea.

The President's Page

To the Members of the Medical Society of Delaware:

The picnic at the Delaware State Hospital, although the weather was distinctly unfavorable, was a very marked success. The hospitality of the superintendent could not have been more pronounced, and I am sure those who had not seen the institution before were impressed by the efficiency, neatness and thoroughness which was evident everywhere. Likewise was the crowding very evident, but this will be taken care of after the acquiring of the other large building.

Dr. LaMotte is working diligently on the program for the coming State Convention, and he will have, with the help of others on the committees, a very interesting two days for all of us. The object is to have things varied enough to induce all of us to spend the full time there. There will be very interesting exhibits and other entertainment for our enjoyment. The program will be published in a later issue of THE JOURNAL.

The last six weeks has enlightened me very greatly in the matters of relief, and the fees paid. Those controlling the relief have very distorted ideas as to fees for the medical profession. When I was consulted by them and we discussed what was a nominal sum to cover the actual expense of a call, we decided upon fifty cents for the first call, and thirty-five cents for subsequent calls, plus any actual expense in the nature of drugs, dressings, etc. These sums were agreed upon by me, because I looked upon the word relief in its true meaning. In the course of my political campaign I find that there is another meaning to the word, or at least the true meaning is distorted. When I was handed a copy of the monthly salaries of those working with the Relief Association I realized I had made an error in agreeing to the above schedule. It is absolutely unfair to expect the medical profession to do all of this relief work with no compensation, when others are being paid far beyond their worth.

The election has come and gone, and you all know the results. I only want to again emphasize the fact that I will so conduct the office as to bring dignity and favorable comment to our profession. I hope during my term to prove to the people that their selection was one by which the community as a whole will benefit.

Sincerely,

W. H. SPEER.

EDITORIAL

DELAWARE STATE MEDICAL JOURNAL

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All correspondence regarding editorial matters, articles, book reviews, etc., should be addressed to the Editor. All correspondence regarding advertisements, rates, etc., should be addressed to the Business Manager.

Local news of possible interest to the medical profession, notes on removals, changes in address, births, deaths and weddings will be gratefully received.

All advertisements are received subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association.

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VOL. V.

JUNE, 1933

No. 6

OUR MAYOR, THE DOCTOR

The Wilmington election of June 3, 1933, resulted in an overwhelming victory for our colleague, Dr. William M. Speer, Democrat, and the current president of the Medical Society of Delaware. Dr. Speer's personal platform was aimed principally at a "new deal" for the taxpayer. Regardless of party affiliation and independent of personal choice, this election to such an important office in this state of another physician should be a matter of congratulation to Dr. Speer and to every member of our profession.

Any physician who, like Dr. Speer, consents to serve his community in any governmental capacity knows beforehand that it entails a great professional sacrifice. The emoluments of the office certainly would not attract men of such

calibre; the only inducement is the sense of public duty to which no high-minded man can say nay. If traditions and precedents hold, Dr. Speer will leave public office somewhat poorer financially than when he entered it, but we predict he will also leave it with an enviable public record behind him to compensate for his personal loss. We wish him great success.

The history of Wilmington's physician-mayors was briefly summarized in an editorial in the *Wilmington Evening Journal* of June 5, 1933, as follows:

DOCTORS AND THE MAYOR'S OFFICE

During the last 50 years Wilmington has elected eight physicians to the office of mayor, Dr. William H. Speer, elected last Saturday, of course, being the eighth. The first chief Burgess (an office equivalent to that of mayor of the present day), was a physician. He was Dr. George Monro, who was elected in 1809 under the first borough charter, which was passed by the Legislature in that year.

Furthermore Dr. Monro was elected for the second time, in 1815. James Brobson intervened, serving during the year 1814. From that time until 1882, however, the medical profession, so far as history indicates, appears to have been out of the picture.

The first chief Burgess Wilmington ever had, it may be of interest to state, was William Shipley, who began his term in 1739. He was named in a borough charter granted that year by Governor John Penn.

This charter was granted on the petition of 103 citizens, who asked that "they may be empowered to choose burgesses and inferior officers as shall be found necessary for the encouraging virtue, preserving the King's peace and the detecting of vice, that they may be enabled to form and enact such ordinances for the regulation of the markets and streets, and cleansing and mending the streets and highways within the precincts of said town, or borough, as may prove commodious both to the said town and country adjacent, etc."

Dr. John P. Wales, who was elected mayor in 1882, was the first member of the medical fraternity to be elected under Wilmington's first charter as a city, which was granted in 1832. He served until 1885.

The second physician to become mayor of Wilmington was Dr. E. G. Shortlidge, who served from 1893 to 1895. Dr. Shortlidge also was president of the Board of Education for a number of years, serving as a member of the board over a considerable period of time.

Dr. Charles R. Jefferis, a prominent dentist, was the third doctor to become mayor under the 1832 charter. He served from 1895 to 1897. Dr. John C. Fahey, the fourth, served from 1899 to 1901; Dr. J. Harvey Spruance, the fifth, from 1909 to 1911.

Dr. Harrison W. Howell, the sixth, was elected for two terms, his tenure of office extending from 1911 to 1915. Dr. George W. K. Forrest, the seventh member of the medical fraternity to fill the office of mayor, had the distinction of serving four consecutive terms, beginning in 1923 and ending in 1931.

Up to 50 years ago the citizens appeared to rely chiefly upon non-professional men, tradesmen and industrialists, apparently, being preferred. But, then, tastes do change, and, very often, for no apparent reason.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely free to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages, but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve you.

Delaware will be represented this year in the House of Delegates of the A. M. A. by Dr. Charles E. Wagner, the alternate, since Dr. James Beebe was unable to attend.

Also going to Milwaukee is Dr. M. A. Tarumianz, who attended the recent sessions of the American Psychiatric Association in Boston.

Dr. C. C. Neese will also attend the A. M. A., as well as the meeting of the American Proctologic Society. All of the Delawareans going to the A. M. A. will visit the Chicago Fair.

The very fact that the public expects full knowledge and successful treatment from any doctor who is called in is a high compliment to the profession. The patient who complains that three or four doctors were needed before one was found to make a correct diagnosis ignores the time element. Perhaps the first doctor, at the later date, would have been quite as accurate in interpreting symptoms. The scope of medicine and surgery has so greatly increased in recent years that a diagnosis is no longer a matter of looking at a tongue and taking a pulse. Much unwarranted criticism of physicians may be laid to the fact that each man's health is to himself "so emotional and personal an affair" that he can scarcely judge his doctor with disinterested intelligence. A throbbing earache will warp the soundest judgment.—THE NEW YORK TIMES.

It is rumored that the Wilmington osteopaths are planning to open their own hospital soon. According to the story, they have leased Mrs. Turk's hospital for a term of several years, and are making a number of renovations. It is understood that Mrs. Turk will act as superintendent, and that the staff will include all the local osteopaths, one of whom will be the surgeon, another the otolaryngologist, etc. It remains to be seen whether the venture can be made a success.

Medical men take notice! We learn from the public press (confirmed by the encyclopedia) that a porpoise is not a fish but a *mammal*. Those surgeons who live along the seacoast have been derelict—not a single case of porpoise mastitis has been reported. And the pediatricians are equally at fault—no case of morasmus has been reported among the sucklings. Moreover, the physiological chemists are due for a razzing—they have not told us the composition of porpoise milk! Yes, yes, it's a fish story, but nevertheless the authorities assure us the porpoise is *not* a fish.

ODE TO THE NURSES

is the title of a poetic pean of praise we recently encountered, written by an ex-patient in a hospital. All joking aside, it really didn't seem so bad—we are sure the lines actually rhymed; but now that we want it, for your benefit, we can't find it.

Small matter, however. The main thing now is to find that sympathetic and sentient soul who can do justice to the

OWED TO THE DOCTORS

WOMAN'S AUXILIARY

THE HAND-BOOK

This seems the time and place to make an announcement of this splendid Auxiliary aid. The Hand-book is a pamphlet of 44 pages $7\frac{1}{2} \times 10\frac{1}{2}$ inches. In addition to the foreword and historical sketch the four parts give us: Part I, Reasons for a Woman's Auxiliary, and Review of Present Functions; Part II, Administration, Duties and Responsibilities of State Officers and of the State Organization Chairman; Part III, Education, Duties and Responsibilities of the

State President, and Chairmen of Program, Hygeia, Public Relations and Press and Publicity; Part IV, the State Convention, Purpose, Program, Factors that Make for Success, and Technique. Helpful instruction and suggestions for county Auxiliary units are given and are involved with those for state officers.

The Hand-book was issued by Mrs. McGlothlan and some of her chairmen during her administration to comply with requests from numerous state presidents and chairmen for a guide for carrying on work in the state and county Auxiliaries. In tentative form it was sent to state presidents and national officers with the request that, after having studied it and having used the practical suggestions, they criticize it and send in suggestions for improving it.

On the basis of the suggestions received Mrs. McGlothlan last summer revised the original Hand-book, added Part I, "Reasons for the Auxiliary; a Review of Its Present Functions" and asked Mrs. Freeman to add the section in Part II on Administration and those pages in Part IV, "The State Convention" dealing with technique.

Mrs. McGlothlan herself says of the Hand-book:

"'Know Your Auxiliary' is the slogan of the Auxiliary this year. It is believed that a study of this Hand-book by present and prospective officers and by all other Auxiliary women as well will tend to unify our organization both as to purpose and as to methods of work. In our letters to state presidents and chairmen earlier in the year it was suggested that the Hand-book be used as a guide and in addition that it be used as a basis for conference discussions in county Auxiliaries, at state conventions and at the national convention. We trust that constructive suggestions growing out of such conferences will be made a matter of record for future use when another revision is found desirable.

"Those who prepared this Hand-book do not claim perfection for it, they regard this revision as the second of a series of steps in the right direction. The suggestions which it contains have grown out of the experience of the many informed, earnest and wise workers who have promoted the growth of the organization from its beginning until now. The Hand-book is not a static thing. As our organization grows and our experience enlarges, changes must be made.

"At present we trust that it may serve as a guide for new officers and chairmen, as a source of helpful information to all members and that those with experience will co-operate in making it more complete and continually better suited to our needs. To whichever class you belong you can make your contribution only by a thorough study of the Hand-book."

If you do not have your copy already, order it now from Mrs. J. Newton Hunsberger, 514 West Main Street, Norristown, Pennsylvania. The price of forty cents for a single copy or \$4.50 for a dozen copies is being charged to help defray the expense of printing and distribution.

The following message comes to you from Mrs. McGlothlan as Chairman of Program and Health Education:

"The letters that come to my desk daily from state and county Auxiliary Presidents, Health Education and Public Relations chairmen asking for literature for use in Auxiliaries and in other organizations prove the growing interest in this phase of our work."

MISCELLANEOUS

Temporary Emergency Relief Commission—New Regulations

TO ALL PHYSICIANS ISSUING PRESCRIPTIONS
FOR CASES OF THE TEMPORARY EMERGENCY
RELIEF COMMISSION

After thoroughly investigating our past business with the druggists it is evident that a new policy should be created in order to place this type of relief on a more economic basis for the benefit of not only the relief cases but in protection of the state funds. In doing this it will be necessary to receive your co-operation on the following:

In issuing prescriptions, when it is possible to do so, we request that you prescribe standard U. S. P. drugs instead of prepared preparations, which as you know are very much higher in price.

It has been brought to our attention by the retail drug trade that a considerable amount of luminol is being used in the prescriptions issued to our cases. We were informed that we could reduce our cost approximately 75% if phenobarbital would be prescribed for luminol, which

it is believed would be just as efficient. Other examples are shown on the attached list of "Trade Names and Common Names of Medicines" as prepared by the American Medical Association.

The Commission has set standard prices, with a substantial discount, to be used in filling prescriptions. The list price is based on the following table:

1 Oz. Liquid	8 Oz. Liquid	12 Powders
2 Oz. "	12 Capsules or Tablets	24 Powders
3 Oz. "	18 " "	½ Oz. Ointments
4 Oz. "	24 " "	1 Oz. "
6 Oz. "	30 " "	2 Oz. "

In order that our Accounting Department can properly audit the prescription bills, it will be necessary for you to note at the top of your prescription, *in English*, the quantity of medicine contained in the prescription. This will also enable our Case Work to know the amount for which our order is to be written.

We appreciate for our clients, as well as ourselves your co-operation in the past and trust that you will be willing to co-operate with us in this matter, in further serving our fellow citizens, who are now living under adverse circumstances. At the same time you will be protecting the interests of the State under whose sponsorship we are working.

Yours very truly,

W. D. Smith,
Relief Director.

May 29, 1933.

TO ALL PHYSICIANS ISSUING PRESCRIPTIONS
FOR CASES OF THE TEMPORARY EMERGENCY
RELIEF COMMISSION

At a joint meeting of the Relief Directors of the Wilmington-New Castle County Area of the State of Delaware Temporary Emergency Relief Commission and physicians representing the State and County Medical Societies, the following rules and charges were agreed upon and will go into effect immediately:

1. It was agreed that the fee* charged for the initial visit of a physician to one of our relief cases should be fifty cents, and thirty-five cents for each subsequent visit.

2. The initial visit shall be construed to mean the first visit made by the physician on any one spell of sickness, and that two initial charges

could not be made on the same sickness of any one patient.

Temporary Emergency Relief Commission, New Regulations; Miscellaneous No. 1—Galley 2

3. Twenty-five cents was the amount agreed upon as a fee for all office calls.

4. In cases of pregnancy and miscarriage, the patients should be sent to a hospital. When it is impossible to admit them to a hospital, the charge for treating them at home should in no case exceed \$15.00, this charge including all supplies used in connection with the case such as bandages, etc.

5. In cases of pneumonia, and long-time illnesses where the physician must make more than one call a day, in order to watch the disease, reimbursement will be made for each call made.

6. Where more than one person is treated in a family at the same time no extra charge will be made, except the actual expense of bandages or medical supplies used.

7. When the physician is called in on a case, without the authority of the case worker, the physician should call the case worker and obtain authorization before making the call. The only exception to this rule being on Saturday afternoons and Sundays when our case workers are not on duty.

Yours very truly,

W. D. Smith,
Relief Director.

May 29, 1933.

PREPARATIONS NOW RECOGNIZED BY THE U. S.
PHARMACOPEIA IN LIEU OF TRADE MARKED
PREPARATIONS

The following list shows the trade names and common names of a few drugs, as prepared by the American Medical Association:

Standard U. S. P. Drug	Trade Name Drug
Phenobarbital	Cost 75% less than Luminol
Amidopyrine	Cost 50% less than Pyramidan
Thymol Iodide	Cost 60% less than Aristol
Quaical Carbonate	Cost 50% less than Cresototal
Silver Nucleinate	Cost 60% less than Protargal
Barbital	Cost 75% less than Veronal
Theobromine & Sodio Salicylate	Cost 75% less than Diuretin

May 29, 1933.

Liquor Control Regulations

Under the Liquor Control Act in the State of Delaware there occur the following paragraphs in regard to licensing of physicians:

*Ed. Note—The "fees" mentioned here are not regarded actually as fees, but as reimbursements for expenses incurred, chiefly in transportation. The word "allowances" would be more descriptive.

Section 17 (8-a)—“Any individual holder of a certificate to practice medicine and surgery in the State of Delaware under license granted under Chapter 27 of the Revised Code of Delaware.”

“May purchase from the Commission or through the Commission as provided in Section 16, paragraph 4, but not otherwise keep and sell to his or her patients ‘alcoholic liquor’ (alcohol, spirits, wine or beer) for medicinal, surgical, or sterilization purposes only, and may charge for such alcoholic liquor not more than the price paid therefor, or may use ‘alcoholic liquor’ for purposes of compounding medicines or alcohol for purposes of sterilization.”

* * * *

Section 16 (4)—The Commission shall sell and deliver all alcoholic liquor purchased, by holders of license under this Act for the purpose of reselling or of dispensing such alcoholic liquor, unless otherwise provided herein, and shall sell and deliver all alcoholic liquor purchased by holders of license to purchase such alcoholic liquor for stock * * ”

* * * *

Section 30 (14)—The fee payable “for a license for a physician, dentist or veterinarian to sell ‘alcoholic liquor’ to his or her patients for medicinal or surgical purposes only, or to use ‘alcoholic liquor’ for compounding medicines or to use alcohol for purposes of sterilization, the sum of one dollar.

* * * *

Application blanks for licenses will be ready at the office of the Delaware Liquor Commission, 1019 Orange Street, Wilmington, Del., shortly after the first of June and operations under the Act will begin on June 14.

In making reply it will be helpful to the Commission if you will state the approximate amount of alcoholic liquors of different kinds that you will likely require, the names of any special brands that you might wish and the place where this alcoholic liquor has been obtained in the past.

It is the intention of the Commission to keep in stock such reasonable quantities of alcoholic liquor as may be required by the physicians of the State. At times it may be necessary to place special orders for stock not on hand. Anticipa-

tion of requirements will be helpful in avoiding delay.

Your earnest cooperation in the administration of the law is solicited and the Commission will appreciate any suggestions for betterment of service and of administration of the Act.

Very truly yours,

The Delaware Liquor Commission,
Pierre S. du Pont.

May 25, 1933.

Plastic and Reconstructive Surgery

The following resolution condemning sensational presentations of plastic surgery by irresponsible and non-representative individuals and groups was adopted by the Society of Plastic and Reconstructive Surgery at its stated meeting at the N. Y. Academy of Medicine on May 26.

“Whereas, sensational stories frequently appear in lay publications concerning the cosmetic repair of the face and body with special reference to the correction of nasal malformations and the eradication of the stigma of age; and

“Whereas, these stories convey the erroneous impression that plastic surgery is purely for cosmetic purposes and involves procedures that may safely be performed by lay cosmeticians in an environment that does not provide the strict asepsis and other safeguards of a hospital operating room; and

“Whereas, these stories are designed to appeal to, and promote the exploitation of, unstable and often psychopathic individuals who have no genuine deformity but are overly sensitive to negligible imperfections and the changes wrought by age,

“Therefore Be It Resolved, That the Society of Plastic and Reconstructive Surgery take steps to inform the public

“(1) that plastic surgery is a regular surgical specialty, embracing the reconstruction of defects and malformations that interfere with normal function as well as the repair of gross cosmetic deformities;

“(2) that those engaged in the practice of Plastic and Reconstructive Surgery require the same scientific and technical training as the practitioners of any other surgical specialty and are bound by the same ethics, adopted in the in-

terests of the public, that govern all reputable physicians, and

"(3) that the safe performance of even minor plastic and reconstructive procedures demands the precautions and safeguards of a first grade operating room;

"And Be It Further Resolved, That this Society condemn the performance of any plastic operations whatsoever by lay cosmeticians and the use of beauty shops, hotel suites, and convention halls for this purpose;

"And Be It Further Resolved, That this Society warn the public of the dangers of any surgery at unqualified hands and the unreliability of sensational, self-aggrandizing publicity;

"And Be It Further Resolved, That this Society urge the community to recognize the social aspects of plastic and reconstructive surgery and make it available, at competent hands, to the poor as well as the rich in cases where cosmetic or functional repair is genuinely indicated.

Incidence of Femoral Hernia Following Repair of Inguinal Hernia— Ectopic Recurrence: Proposed Operation of External and Internal Herniorrhaphy

Edward Raymond Easton, New York (*Journal A. M. A.*, June 3, 1933), outlines a method for the performance of an external and internal herniorrhaphy in which the inguinal region is exposed through an incision from a point half an inch above Poupart's ligament, at the junction of its outer and middle thirds, downward and inward to a point half an inch above the spine of the pubis, whence the incision is extended across the midline transversely for the distance of 1 inch. If the operation is for a double hernia, the incision is continued in like manner on the other side. The incision is deepened to and through the aponeurosis of the external oblique, dividing the external ring in the direction of its fibers. The procedure from this point depends largely on whether an adherent sac or contents are found after the sac is dissected free from the cord. If the sac is dissected free without difficulty or without adherence of the contents, the rectus sheath is then incised transversely according to the Pfannenstiel method at a point above the crest of

the pubis in line with the internal ring. The transverse incision need be no more than $2\frac{1}{2}$ inches long. The peritoneum is then opened in the midline and the internal opening of the hernia dealt with by inversion of the hernial sac into the abdomen, all of the sac except a fringe or margin about three-fourths of an inch wide being trimmed off. A purse-string suture is then placed in the neck of the sac and tied within the abdominal cavity. The remaining free edge of the sac is then turned back and tacked down throughout its circumference by interrupted catgut sutures through the peritoneum, so as to form a plug, or button-like structure. Then the peritoneum is grasped laterally to this area with several Kocher clamps and sutured over the preceding layers of the hernial sac. If, however, the sac has been found adherent and prolonged into the scrotum, it is dissected free at the internal ring sufficiently to allow a cuff 2 inches in length to be inverted into the peritoneal cavity, where it can be treated in the same manner as described. If any contents, such as omentum, intestine or bladder, are found in the sac, it is of distinct value to open the peritoneum through the Pfannenstiel incision before attempting resection of the sac, so that the condition on the inside of the cavity may be observed and dealt with from that angle. The original incision is then closed by the method advised by Pfannenstiel, the rectus sheath being sutured with interrupted chromic sutures. After the rectus sheath has been repaired, the inguinal operation is continued with whatever form of repair seems appropriate for the individual case. In general, a type of operation such as Ferguson's seems appropriate for indirect hernia, while the Halsted method, with the use of a flap of rectus sheath in case of a deficiency of the conjoined tendon, would be better for the direct hernia. The incision is then closed with interrupted or continuous sutures. The author believes that the method presents the following advantages: (1) high removal of sac; (2) allowance for (a) a thorough inspection of the bladder, omentum, intestine or other contents of the sac, (b) complete repair of all the layers of the abdominal wall, (c) removal of the appendix, or the performance of other surgical procedure through the midline not incompatible with the repair of the hernia, (d) tightening up by plication of

any preformed hernial sac (dimple, diverticulum or unclosed funicular process) at any other hernia site (direct or femoral), and (3) the putting of a cork, or plug, in the neck of the hernial sac.

Trichomonas Vaginitis in Children

During the past two years, Lester E. Frankenthal, Jr., and Alfred J. Kobak, Chicago (*Journal A. M. A.*, June 3, 1933), observed four cases of *Trichomonas vaginitis* in children. All the patients were between the ages of 11 and 14 years. Three of these cases were seen before the onset of menstruation. In each patient a history of profuse, irritating vaginal discharge was elicited. On examination, the authors found in all four a bubbly, foamy, gray to green discharge which bathed the external genitals and irritated the surrounding skin. Vaginoscopic examination showed the vagina to be definitely affected, and the summits of the rugae contained small punctate hyperemic spots. The latter were especially noted around the cervix. The diagnosis of this condition is easy to make. Routine vaginoscopic and hanging drop examination should be made in all suspected cases. The local treatment in children is very difficult and unsatisfactory because of the virginal introitus and infantile state of the genitals. Improvement of local and general hygiene together with a well balanced diet is beneficial. The one patient limited to these measures made the most satisfactory progress. The course of this infection is prolonged in childhood and it is more difficult to effect a cure than in adults.

Diphtheria Mortality in Large Cities of the United States in 1932: Tenth Annual Report

The Tenth Annual Survey (*Journal A. M. A.*, May 20, 1933), of diphtheria concerns the ninety-three cities dealt with in the recent article on typhoid (*Journal A. M. A.*, May 13, 1933), and the rates are calculated on the basis of the population figures used in that article. The New England group again makes a new low record (3.65), some individual cities registering a low rate for the third consecutive year. The cities in the Middle Atlantic states better their excellent record of 1931 and easily main-

tain their ranking as the group of lowest diphtheria mortality. Several of the South Atlantic cities show notable improvement over preceding years, Richmond, Baltimore and Wilmington all having low rates. The three Florida cities Tampa, Jacksonville and Miami, on the other hand, report rates that indicate an excessive prevalence of diphtheria. The East North Central cities, which in 1925 to 1929 had the highest average diphtheria rate of any section of the country, have made the greatest relative improvement and now are second only to the Middle Atlantic cities. The East South Central cities, as a whole, do not show much change from the preceding year. Although the group rate for the cities of the West North Central states does not register much change, individual cities such as St. Paul, Minneapolis, Kansas City, Mo., and particularly St. Louis, show steady improvement. Six of the eight West South Central cities show an increase in 1932 over 1931 and the group as a whole has an average rate of 8.16 in 1932, as against 5.93 in 1931. The Mountain and Pacific group of cities shows an increase in the diphtheria rate from 2.71 for 1931 to 3.43 for 1932. Tacoma being the only city in the group to register a reduction. At the present time, the cities in the United States that have a cold winter and a generally "bad climate" are faring considerably better with respect to diphtheria than the Southern cities and the climatic resorts of the Western coast. Long term records, however, will be necessary for the proper interpretation of these somewhat surprising records.

Diagnosis and Treatment of Addison's Disease

During the past two and a half years, George A. Harrop, Albert Weinstein, Louis J. Soffer and J. H. Trescher, Baltimore (*Journal A. M. A.*, June 10, 1933), treated thirteen cases of Addison's disease by means of the suprarenal cortical extract made according to the method of Swingle and Pfiffner. The diagnosis of each of these cases they have regarded as unequivocal. There were seven deaths. The other six patients are now living. All of the seven fatal cases have come to necropsy, and the clinical diagnosis of Addison's disease has in each been proved correct. Four were due to cortical

atrophy. The authors believe that the clinical value of injections of the cortical hormone as a routine treatment during the remissions of Addison's disease has not been satisfactorily demonstrated. So far as their experience indicates, however, there is no danger whatever in the use of extract if this seems desirable. They stress the fact that they have never seen any untoward or toxic effects as a result of the treatment by cortical extract, although they have used it in many types of patients, some of whom have received large doses both subcutaneously and intravenously. The authors do not doubt, however, that a faulty preparation may lead to dangerous consequences. The extract has no definite effect on hypotension or on the pigmentation. They are not convinced that it has any effect on nutrition and weight. The chief value of the cortical extract lies in the treatment of the relapse, the symptoms of which they regard as fundamentally those of shock, and due primarily to cortical deficiency. In patients showing such symptoms for longer or shorter periods, injections of the cortical hormone extracts are of definite value and may be of vital importance.

BOOK REVIEWS

HOW TO BUDGET HEALTH: GUILDS FOR DOCTORS AND PATIENTS. By Evans Clark, Director, Twentieth Century Fund. Pp. 328. Cloth. Price, \$4.00. New York: Harper & Brothers, 1933.

This volume, which follows close upon the report of the Committee on the Costs of Medical Care, proposes that physicians form "medical guilds" which would offer the services of general practitioners, assisted by specialists, as well as hospital care when needed, to member patients at a fixed annual rate. This system, the author claims, by applying to the maintenance of health the same methods of organization which have proved successful in other forms of enterprise, would reduce both operating and consumer cost; by preserving the independence of the medical profession, would avert the evils of state and other forms of "socialized medicine" which put doctors on government or corporation payrolls to take orders from politicians or business executives; and, by the fixed rate plan, would provide health care for the public at a specified and unvarying cost.

An estimate of the annual fee, based on past and present experience in similar types of group practice, is given in the book. Excluding the insane and the tubercular, it is calculated that a unit of 32 full-time and 7 part-time physicians and dentists could serve 15,000 patients at a cost of \$50 to \$60 per year per individual with the assurance that this amount would never be increased. Under present conditions it is impossible to know in advance when the cost of illness may rise to \$500 or \$5,000 in a single year.

Under the guild plan, the general practitioner and his associated specialists would be consulted under the same roof. Here they would jointly own an adequate equipment, including x-ray and analytical laboratories, operating rooms, an efficient clerical force and record files; and here the health record would be taken once and be always available. Here also the periodic examination would be made. The cost of all this service would be included in the annual fee.

Following is a summary of the advantages cited in the book for the plan:

1. Each patient member would be able to include in his personal budget an exact item of expense for any illness which might occur, and could prepare to meet it just as he now meets his life insurance payments.
2. The expenses of the physicians would be reduced by sharing equipment and overhead, and fee-splitting would be eliminated. Therefore the cost to the patient would be materially reduced without sacrifice on the part of the physicians.
3. Periodic medical examinations would prevent illness to a marked degree.
4. Since the fee is paid whether the patient be sick or well emphasis would be placed upon keeping him well rather than curing his ailments—and in either case the physicians' income would remain the same.
5. The principle of the "fixed price" so valuable in the commercial world would at last be established in medicine, and the doctor would no longer need to worry about the amount of his patient's income.
6. Nor would the physician need to worry about his own income. This should be guaranteed in advance by the dues already in the treasury; and it should be substantially higher than prevailing levels in private practice under present conditions.

7. The plan would relieve the physician as an individual of the office routine of bookkeeping, billing, making case records, and filing. These duties would be performed by people better trained for them than he is.

8. Enlarged opportunities for consultation and observation would increase the physician's efficiency.

9. With better facilities in his practice the physician would be able to find more time for recreation and study.

10. The physician would be relieved of the problems of making collections.

11. The public is demanding better and less expensive medical care. This offers a way to provide it without sacrificing control of its own activities by the medical profession.

Nevertheless, the book does not convince one that the "guild" idea is the answer. In the smaller communities where the specialties are represented only in part or not at all, it would not be applicable. Even in large cities, the choice of consultants would be limited to the staff or personnel of the guild, thus limiting the patient's free choice of physician. Furthermore, unless all the hospitals in a city were parties to the guild idea, with their doors wide open to the entire medical profession of the community, the plan would limit the patient's free choice of hospital. Finally, the family budgeting required can be carried out only by those with assured jobs, a Utopian condition not yet realized. It appears to us that much time and still more evidence in favor of the guild plan will be necessary before it can win general approval.

THE FIVE-YEAR PROGRAM OF THE COMMITTEE ON THE COST OF MEDICAL CARE. Pub. No. 1, C. C. M. C. Pp. 39. Paper. Price, 25 cents. Chicago: University of Chicago Press. 1928.

THE EXTENT OF ILLNESS AND OF . . . DEFECTS . . . IN THE UNITED STATES. Pub. No. 2, C. C. M. C. Pp. 83. Paper. Price, 50 cents. Chicago: University of Chicago Press. 1929.

A SURVEY OF STATISTICAL DATA ON MEDICAL FACILITIES IN THE UNITED STATES. Pub. No. 3, C. C. M. C. Pp. 119. Paper. Price, 50 cents. Chicago: University of Chicago Press. 1929.

HOSPITAL SERVICE FOR PATIENTS OF MODERATE MEANS. Pub. No. 4, C. C. M. C. Pp. 105. Paper. Price, 50 cents. Chicago: University of Chicago Press. 1930.

MEDICAL CARE FOR 15,000 WORKERS AND THEIR FAMILIES. A Survey of the Endicott-Johnson Workers Medical Service: 1928. Pub. No. 5, C. C. M. C. Pp. 95. Paper. Price, 50 cents. Chicago: University of Chicago Press. 1930.

A SURVEY OF THE MEDICAL FACILITIES OF SHELBY COUNTY, INDIANA: 1929. Pub. No. 6, C. C. M. C.

Pp. 213. Paper. Price, \$1.00. Chicago: University of Chicago Press. 1930.

A SURVEY OF THE MEDICAL FACILITIES OF THE CITY OF PHILADELPHIA: 1929. Pub. No. 9, C. C. M. C. Pp. 298. Paper. Price, \$1.50. Chicago: University of Chicago Press. 1931.

A STUDY OF PHYSICIANS AND DENTISTS IN DETROIT: 1929. Pub. No. 10, C. C. M. C. Pp. 50. Paper. Price, 25 cents. Chicago: University of Chicago Press. 1931.

THE "MUNICIPAL DOCTOR" SYSTEM IN RURAL SASKATCHEWAN. Pub. No. 11, C. C. M. C. Pp. 84. Paper. Price, \$1.00. Chicago: University of Chicago Press. 1931.

These nine publications of the late Committee on the Costs of Medical Care comprise those titles which had not been received previously. The titles themselves indicate sufficiently, for our present purpose, their contents. These volumes, like the others in the C. C. M. C. series, are replete with pertinent facts; and, together with the others, constitute the largest mass of data extant upon our medical care problems. The deductions to be made and the remedial plans to be pursued can safely be—in fact, had better be—left to the state and county medical societies and their committees on medical economics.

NEW AND NONOFFICIAL REMEDIES, 1933, containing descriptions of articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1933. Cloth. Price, Postpaid, \$1.50. Pp. 498; lvi. Chicago: American Medical Association.

The annual editions of this volume contain all that the busy physician needs to know concerning the newer preparations which he is daily importuned by the detail men of the pharmaceutical manufacturers to use. The remedies listed and described here have been examined and found acceptable by the Council on Pharmacy and Chemistry, the deliberative body charged by the American Medical Association with the performance of this service for the practitioner, who has not the time or means to make the determinations for himself. Among the new preparations admitted during the past year are: Trichlorethylene-Calco, an inhalation anesthetic proposed especially for use in trigeminal neuralgia; Nostal, an additional barbituric acid compound; Decholin and Decholin Sodium, bile salt preparations for use in functional insufficiency of the liver, the sodium salt being suitable for intravenous use when necessary; Biliposol, Bismo-Cymol, and Iodobismitol, bismuth compounds for use in obtaining the systemic effects of bismuth, especially in syphilis; Triphal, a gold salt proposed for use in the treatment of

lupus erythematosus; a number of improved liver preparations for use in the treatment of pernicious anemia; two halibut liver oil preparations of high vitamin A and vitamin D content; and Pentnucleotide, the sodium salts of the pentose nucleotides derived from the ribonucleic acid of yeast, proposed for use in infectious conditions accompanied by a leukopenia or neutropenia.

The book contains general articles, descriptive of the classification under which the various drugs are listed. According to the preface, more or less thorough-going revisions have been made of the articles: Arsenic Compounds; Dyes, Iodin Compounds; Liver and Stomach Preparations; Radium and Radium Salts and Silver Preparations.

ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1932. Cloth. Price, \$1.00. Pp. 104. Chicago: American Medical Association.

The Council on Pharmacy and Chemistry still carries on its work of informing the medical profession concerning the new medicinal products brought out by the various manufacturers of pharmaceuticals. This volume contains the reports on products considered and rejected by the Council during the past year. Among the reports of special interest are: Amertan, an original mixture of tannic acid and merthiolate in a water soluble jelly, marketed under a proprietary, uninforming name; Antiopin, a mixture of indefinite composition offered under a nondescriptive, therapeutically suggestive name and marketed in a way that may foster the drug habit; Eubetin, another insulin substitute for oral administration marketed under a proprietary uninforming name with unwarranted claims; Ferro-Copral, a mixture of saccharinated ferric oxide, manganese citrate and copper proteinate proposed for use in the treatment of pernicious anemia and marketed under a proprietary name with unwarranted therapeutic claims; Hepatex P.A.F., a liver preparation proposed for intravenous use and marketed under a proprietary and insufficiently descriptive name with no satisfactory evidence of the safety of its recommended intravenous use; Bi-So-Dol, an unscientific "alkalinizing" mixture offered under an uninforming proprietary name with exaggerated and unwarranted claims of therapeutic usefulness;

Gan-Aiden, consisting mainly of the well known ethyl amino-benzoate (benzocaine), a preparation of undeclared composition marketed under a noninforming, proprietary name; Myodin, Subidin, and Sanguiodin, unscientific preparations of iodine marketed with unwarranted claims and indefinite, incorrect statements of composition, under proprietary uninforming names and Tonikum-Roche (Now Elixir Arsylene Compositum-Roche), a "shot-gun" proprietary "tonic" marketed with misleading therapeutic claims.

Besides the reports on rejected articles, the volume contains "Preliminary" and "Special" reports of exceptional timeliness and value: The preliminary report on Thorotrast, a colloidal thorium dioxide preparation proposed for use in retrograde pyelography and for roentgen visualization of the liver and spleen by intravenous administration, is an excellent example of this class of reports. The articles on Nirvanol and Triethanolamine are also interesting and effective preliminary reports. Among the "special" reports those on Sulpharsphenamine and Mercurochrome are outstanding. Each report definitively clears up the present status of the drug concerned, the former, on the basis of a questionnaire circulated among leading syphilologists, and the latter on the basis of independent bacteriologic investigation, done by consultants of the Council.

WHEAT, EGG, OR MILK FREE DIETS. By Roy M. Balyeat, M. D., Associate Professor of Medicine, University of Oklahoma. Pp. 136. Cloth. Price, \$2.50. Philadelphia: J. B. Lippincott Company. 1933.

Dr. Balyeat has written a very interesting book, in which he has arranged many practical and unlimited recipes for egg, wheat and milk sensitive patients. The work entailed in arranging the many diets and special recipes can readily be appreciated by the profession and laity as well. The simplicity and detailed instruction to the allergic patient, with brief explanations as to the relation to disease, is very convincing, although many of the statements are not definitely proven. There is much to be learned about food allergy as a cause of symptoms. This little book points the way.

The method of testing individuals is neither new nor difficult, and should be employed more often in many of our obscure cases of Migraine and Gastric Intestinal disturbances.

